Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2681HOS	A. BUILDING _____ B. WING _____	05/08/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROGRESSIVE HOSPITAL	4015 SOUTH MCLEOD LAS VEGAS, NV 89121

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S 000	Initial Comments This Statement of Deficiencies was generated as a result of a State Licensure survey conducted at your facility on 05/05/09 though 05/08/09, in accordance with Nevada Administrative Code, Chapter 449, Hospitals. The census at the time of the survey was 14 patients. Fourteen patient files were reviewed. Six closed patient files were reviewed. Twenty four employee files were reviewed. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified.	S 000		
S 070 SS=D	NAC 449.3154 Construction Standards 1. Except as otherwise provided in this section, a hospital shall comply with the provisions of NFPA 101: Life Safety Code, pursuant to section 1 of this regulation. This Regulation is not met as evidenced by: The current edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) is the 2006 edition, using Chapter 18, "New Health Care Occupancies."	S 070		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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S 070	Continued From page 1 This REG is not met as evidenced by: 1) Chapter 8 Features of Fire Protection 8.3 Fire Barriers 18.3.7.5 Materials and methods of construction used for required smoke barriers shall not reduce the required fire resistance rating. Based on observation on 5/21/09, the facility failed to maintain the fire resistance rating of the 1 hour fire/smoke wall for 1 of 3 fire/smoke walls in the building. Findings include: The southeast fire/smoke wall had 1 inch and 1/2 inch flexible conduit penetrating the 1 hour fire wall. These conduits were not caulked with fire caulk to seal against the passage of smoke in a fire. There was also a 2 inch water line that was not fire caulked to seal against the passage of smoke in a fire. 2) Chapter 18.3 Protection 18.3.2 Protection from Hazards 18.3.2.1 Hazardous Areas. Any hazardous areas shall be protected in accordance with Section 8.7, and the areas described in Table 18.3.2.1 shall be protected as indicated. Table 18.3.2.1 Hazardous Area Protection Soiled linen rooms 1 hour Separation/Protection 8.7.1.3 Doors in barriers required to have a fire	S 070		

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S 070	Continued From page 2 resistance rating shall have a 3/4 hour fire protection rating and shall be self-closing or automatic-closing in accordance with 7.2.1.8. Based on observation, the facility failed to provide the proper fire-rated door for a hazardous area. Findings include: The south-west soiled laundry room had a 20 minute fire-rated door. 3) 7.9 Emergency Lighting 7.9.2.4 Emergency generators providing power to emergency lighting systems shall be installed , tested , and maintained in accordance with NFPA 110, Standards for Emergency Lighting and Standby Powers Systems. NFPA 110 8.4.3 Diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent nameplate rating for 30 minutes, followed by 75 percent nameplate rating for 60 minutes, for a total of 2 continuos hours. Based on record review, the facility failed to perform the required annual 2-hour load bank test for the emergency generator. Findings include: The facility only had proof of a 1-hour load bank	S 070		

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S 070	Continued From page 3 test dated 2/16/09 performed by their vendor. Severity: 2 Scope: 1	S 070		
S 219 SS=F	NAC 449.340 Pharmaceutical Services 5. Drugs and biologicals must be controlled and distributed in a manner which is consistent with applicable state and federal laws. This Regulation is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure expired medications were not stored at the facility. Findings include: On 05/05/09 at 9:00 AM, the following expired medications were stored inside the facility's medication room. 1. One 1000 cc (cubic centimeter) IV (intravenous) bag 10% Dextrose solution with an expiration date of 09/08. 2. One bottle of Vancomycin 250 mg (milligram)/5cc oral solution located inside the medication room refrigerator with an expiration date of 04/23/09. 3. One bottle of Vancomycin 250mg/5cc oral solution located inside the medication room refrigerator with an expiration date of 05/03/09. 4. One 30 cc vial of Acetylcysteine solution with an expiration date of 09/01/08. 5. One 16 fluid ounce bottle of Hydrogen peroxide located under the nursing station sink with an expiration date of 05/06.	S 219		

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S 219	Continued From page 4 6. One 4 ounce bottle of Bausch Lomb eye wash irrigation solution located under the nursing station sink with an expiration date of 05/03. On 05/05/09 at 9:00 AM, Employee #1 confirmed the expiration dates on the above listed medications and indicated it was the nursing and pharmacy staffs responsibility to check the medications at the facility for expiration dates and remove all expired medications from stock for destruction. Employee #1 indicated a nurse was assigned each shift to check the medication room for expired medication and remove any expired medications from stock. The expired medications were then returned to the pharmacy for destruction. The facility's Medication Storage Policy dated 04/03 indicated all outdated, contaminated or deteriorated medications and those in containers that were cracked, soiled, unlabeled or without closures were immediately removed from stock, disposed of according to procedures for medication destruction, and reordered from the pharmacy, if a current order existed. Severity: 2 Scope: 3	S 219		
S 298 SS=E	NAC 449.361 Nursing Service 9. A hospital shall ensure that its patients receive proper treatment and care provided by its nursing services in accordance with nationally recognized standards of practice and physicians' orders. This Regulation is not met as evidenced by: Based on observation, interview, record review and policy review, the facility failed to ensure patients received proper treatment and care	S 298		

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S 298	Continued From page 5 provided by nursing services in accordance with facility policies and physicians' orders. Findings include: 1. a. Patient #6 On 5/6/09 in the morning, Employee #4 removed the following medications from the facility's medication dispenser/bulk supply for Patient #6: Carvedilol 25 milligrams at 10:30 AM Isosorbide 30 milligrams at 10:30 AM Omeprazole 20 milligrams at 10:30 AM Ferrous Sulfate 325 milligrams at 10:30 AM Employee #4 administered the above four medications at 10:30 AM. Patient #6 took the Ferrous Sulfate tablet without food. Patient #6's physicians' orders and medication administration record (MAR) indicated the above medications were ordered to be administered at 9:00 AM with the exception of Ferrous Sulfate. Ferrous Sulfate was scheduled with meals at 8:00 AM and 12:00 PM. Chapter 5.003 of the facility's medication administration policy under sub-heading #10, which was last revised in April 2003, indicated "medications are administered with one hour before and one hour after the scheduled time..." On 5/8/9 at 11:15 AM, Employee #1 indicated the medication parameters for 9:00 AM daily medications would be 8:00 AM to 10:00 AM, an hour before and an hour after 9:00 AM.	S 298		

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S 298	Continued From page 6 Chapter 5.003 of the facility's medication administration policy under sub-heading #13 indicated "if a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time..., the space provided on the front of the [MAR] for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for [as needed] documentation." Patient #6's MAR lacked the above documentation. The facility failed to follow its policy regarding timely medication administration. b. On 4/11/09, nursing initiated a plan of care alteration in cardiac status. The plan indicated nursing would monitor Patient #6 for fluid overload. The patient weighed 464 pounds. On 4/13/09, the physician ordered daily weights. The facility failed to record daily weights on 4/14/09, 4/15/09, 4/17/09, 4/18/09, 4/21/09, 4/23/09, 4/25/09, 4/26/09, 4/28/09, and 4/29/09. On 5/1/09, the physician ordered daily weights again. The facility failed to record daily weights on 5/1/09, 5/2/09, 5/6/09, and 5/7/09. On 5/7/09, the physician ordered the patient's weight for the morning. The facility failed to record a weight on 5/8/09. The plan of care contained daily weight as a possible individualized intervention on a pre-printed form at admission on 4/11/09; the facility failed to include daily weight on its plan of	S 298		

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S 298	Continued From page 7 care. The plan of care failed to document daily weights. On 5/8/09 at noon, Employee #1 indicated patient weights were either in the graphics section or possibly in the nursing progress notes. A review of Patient #6's graphics sections and daily nursing progress notes lacked documentation of daily weights. c. On 4/14/09, the physician ordered a 1000 milliliter fluid restriction. On 5/13/09 in the afternoon, the ordering physician indicated the restriction applied to fluids by mouth. A review of Patient #6's intake by mouth revealed the patient exceeded the 1000 milliliter restriction every day from 4/29/09 through 5/7/09. The facility did not update the plan of care to include fluid restriction as an individualized intervention after admission on 4/11/09. On 5/5/09, Patient #6 weighed 493 pounds. Patient #6 gained 29 pounds between admission on 4/11/09 and 5/5/09. The facility failed to properly monitor, record, and intervene with physician ordered interventions specific to Patient #6's alteration in cardiac status related to fluid overload. 2. a. Patient #7 On 5/6/09 in the morning, Employee #4 removed the following medications from the facility's medication dispenser/bulk supply for Patient #7: Intravenous lipids 20%/250 milliliters at 10:44 AM Oyster Shell/Vitamin D 500/200 at 10:47 AM	S 298		

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S 298	Continued From page 8 Prednisone 20 milligrams at 10:47 AM Pantoprazole 40 milligram vial at 10:47 AM .9 Sodium Chloride 100 milliliters at 10:47 AM Employee #26 removed .9 Sodium Chloride 100 milliliters and a Pantoprazole 40 milligram vial at 11:13 AM. The medication dispenser's activity report indicated the above medications with the above removal times for Patient #7. Patient #7's physicians' orders and MAR indicated the above medications were ordered to be administered at 9:00 AM. Chapter 5.003 of the facility's medication administration policy under sub-heading #10 indicated "medications are administered with one hour before and one hour after the scheduled time..." On 5/8/09 at 11:15 AM, Employee #1 indicated the medication parameters for 9:00 AM daily medications would be 8:00 AM to 10:00 AM, an hour before and an hour after 9:00 AM. Chapter 5.003 of the facility's medication administration policy under sub-heading #13 indicated "if a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time..., the space provided on the front of the [MAR] for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for [as needed] documentation."	S 298		

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S 298	Continued From page 9 Patient #7's MAR lacked the above documentation. The facility failed to follow its policy regarding timely medication administration. The following was observed during Patient #7's intravenous (IV) Pantoprazole and Lipids administration: -Employee #26 primed the intravenous tubing with the .9 Sodium Chloride bag diluted with Pantoprazole. Afterward, Employee #26 indicated less than half of the Pantoprazole solution remained in the bag. Employee #26 then connected the IV tubing to Patient #7's IV port without cleaning the port. The IV fluid infused by gravity in less than fifteen minutes. Employee #26 clamped the IV tubing leaving the tubing attached to Patient #7 and returned with a second IV bag of .9 Sodium Chloride 100 milliliters and a second vial of Pantoprazole 40 milligrams. Employee #26 removed the tubing from Patient #7's IV port after spiking the new bag mixed with Pantoprazole. Employee #26 proceeded to prime the IV tubing a second time and reattached the IV tubing to Patient #7's IV port without cleaning the port. Employee #26 programmed the IV pump to infuse the 100 milliliter bag in one hour. The MAR indicated the Pantoprazole should infuse over 30 minutes.	S 298		

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S 298	Continued From page 10 The facility failed to follow a physician's order to administer an ordered medication with the proper dose at the proper rate. Employee #26 left the room and returned with the IV Lipids. At 11:53 AM, Employee #26 picked her personal keys off the floor after she had washed and gloved her hands. Employee #26 directly proceeded to flush Patient #7's IV port with 10 milliliters of saline without cleaning the port or removing her gloves and washing her hands again. On 5/8/09 at 11:15 AM, Employee #1 indicated the facility used 10 milliliter syringes with pre-filled saline for routine flushes. Nurses were supposed to use 5 milliliters before and 5 milliliters after an intravenous medication administration. The facility's intravenous catheter care policy, last reviewed June 2007, indicated the following regarding routine flushes for peripherally inserted central catheters: -Three milliliters normal saline followed by 3 milliliters of Heparin 100 units per milliliter. Patient #7's MAR indicated nurses administered 10 milliliters of saline with routine flushes and 5 milliliters of Heparin with routine flushes. The facility failed to follow its policy for routine flushing of peripherally inserted central catheters. The facility's infection control standard regarding intravenous therapy, last reviewed August 2007, indicated "aseptic techniques will be observed	S 298		

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S 298	Continued From page 11 during venipuncture and when entering the [intravascular] system." On 5/7/09 at 3:45 PM, Employee #28 indicated before accessing an IV line, a nurse should remove gloves, wash hands, and then re-glove after picking up objects off the floor with gloves on. IV ports should be swabbed with alcohol wipes before accessing them. On 5/8/09 at 10:50 AM, Employee #1 concurred with Employee #28 regarding aseptic technique and accessing an IV line. On 5/8/09 at 1:45 PM, Employees #31 and #32 concurred with Employees #1 and #28 regarding aseptic technique and accessing an IV line. The facility failed to use aseptic technique before accessing an IV port. The Lipids began infusing at noon, three hours after the scheduled time. The facility failed to follow its policy regarding timely medication administration. c. On 5/6/09, a physician's order indicated 125 milligrams of Solumedrol intravenous piggyback every 12 hours for 4 doses. On 5/6/09 at 3:19 PM, Employee #29 removed a 125 milligram/2 milliliter dose of Solumedrol, mixed it in an IV bag, and infused it. On 5/8/09 at noon, Patient #7's chart lacked documentation the patient received the Solumedrol. On 5/8/09 at noon, Patient #7's chart lacked a	S 298		

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S 298	Continued From page 12 physician's order discontinuing the Solumedrol. The facility failed to follow a physician's order to administer ordered Solumedrol and to document its administration. d. On 5/6/09 in the afternoon, Patient #7 was observed receiving a blood transfusion. The following data are from Patient #7's blood component's flow sheet completed during the observation: At 2:45 PM, Patient #7's baseline temperature was 99.6 degrees prior to the blood transfusion. At 3:00 PM, Patient #7's temperature was 102.3 degrees after initiation of transfusion. At 3:15 PM, Patient #7's temperature was 102.3 degrees. At 3:30 PM, Patient #7's temperature was 102.8 degrees. At 3:32 PM, the nurse stopped the transfusion. On 5/8/09 in the morning, Employee #1 indicated there was no reason to continue to transfuse blood in a patient with a 102 degree temperature unless a physician specifically ordered it. She further indicated the facility's temperature ceiling on transfusions might be 1-2 degrees above baseline. The facility's blood product administration policy regarding reactions, last reviewed February 2007, indicated the following: "1. A transfusion reaction is a physiological	S 298		

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S 298	Continued From page 13 reaction to the infusion of blood or blood products. A reaction may consist of but [may] not [be] limited to: a. Temperature elevation of over 1 degree Celsius or 2 degrees Fahrenheit when not clinically expected. 2. If the patient is suspected of having a transfusion reaction, the following actions are to be taken: a. Stop the infusion of blood..." Patient #7's file lacked an order to continue transfusing with a temperature greater than 102. The nurse waited thirty-two minutes after Patient #7's temperature exceeded a two degree Fahrenheit temperature elevation to stop the transfusion. The facility failed to follow its blood product administration policy regarding reactions. 3. Patient #8 On 5/8/09 at 8:40 AM, Employee #32 administered 4 milligrams of intravenous Zofran to Patient #8. Patient #8 had a peripherally inserted central catheter in her left bicep. After administration, Employee #32 failed to use Heparin flush. The facility's intravenous catheter care policy, last reviewed June 2007, indicated the following regarding routine flushes for peripherally inserted central catheters: Three milliliters normal saline followed by three milliliters of Heparin 100 units per milliliter. Patient #8's MAR indicated Heparin flush per	S 298		

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S 298	Continued From page 14 pharmacy protocol. Patient #8's MAR lacked documentation of Heparin use. The facility failed to follow its policy for routine flushing of peripherally inserted central catheters. 4. Patient #9 On 5/6/09 in the morning, Employee #4 removed the following medications from the facility's medication dispenser/bulk supply for Patient #9: Isosorbide Dinitrate 5 milligrams at 11:05 AM Lisinopril 10 milligrams at 11:08 AM Simvastatin 20 milligrams at 11:08 AM Lovenox 30 milligrams/.3 milliliters injection syringe at 11:09 AM Prednisone 20 milligrams at 11:11 AM Tamoxifen 10 milligrams at 11:15 AM Cipro 500 milligrams at 11:15 AM Employee #29 removed Furosemide 40 milligrams at 11:29 AM. The medication dispenser's activity report indicated the above medications with the above removal times for Patient #9. Patient #9's physicians' orders and MAR indicated the above medications were ordered to be administered at 9:00 AM. Chapter 5.003 of the facility's medication administration policy under sub-heading #10	S 298		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2681HOS	A. BUILDING _____ B. WING _____	05/08/2009

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S 298	Continued From page 15 indicated "medications are administered with one hour before and one hour after the scheduled time..." On 5/8/09 at 11:15 AM, Employee #1 indicated the medication parameters for 9:00 AM daily medications would be 8:00 AM to 10:00 AM, an hour before and an hour after 9:00 AM. Chapter 5.003 of the facility's medication administration policy under sub-heading #13 indicated "if a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time..., the space provided on the front of the [MAR] for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for [as needed] documentation." Patient #9's MAR lacked the above documentation. The facility failed to follow its policy regarding timely medication administration. 5. Patient #12 A review of patients with recent blood transfusions yielded the following: On 5/6/09 in the afternoon, Patient #12's file revealed a transfusion order for two units of blood on 4/17/09. The order was accompanied by a second order to "give Lasix 20 milligrams intravenous between units." Patient #12's MAR documented two 20 milligram doses of intravenous Lasix, 20 milligrams between [two] units and another 20 milligrams after the second unit.	S 298		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2681HOS	A. BUILDING _____ B. WING _____	05/08/2009

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PROGRESSIVE HOSPITAL	4015 SOUTH MCLEOD LAS VEGAS, NV 89121

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S 298	Continued From page 16 On 5/7/09 at 4:15 PM, Employee #28 indicated an order for 20 milligrams of Lasix between two units of blood means giving 20 milligrams of Lasix once. On 5/8/09 at 11:15 AM, Employee #1 indicated an order for 20 milligrams of Lasix between two units of blood means giving 20 milligrams of Lasix once. The facility failed to follow a physician's order and overdosed Patient #12 with Lasix. 6. Patient #14 On 5/6/09 in the morning, Employee #25 removed the following medications from the facility's medication dispenser/bulk supply for Patient #14 (who had a peripherally inserted venous catheter): .9% Sodium Chloride 100 milliliters at 11:38 AM Pantoprazole 40 milligram vial at 11:39 AM Patient #14's physicians' orders and MAR indicated the above medications were ordered to be administered at 9:00 AM. Chapter 5.003 of the facility's medication administration policy under sub-heading #10 indicated "medications are administered with one hour before and one hour after the scheduled time..." On 5/8/09 at 11:15 AM, Employee #1 indicated the medication parameters for 9:00 AM daily medications would be 8:00 AM to 10:00 AM, an hour before and an hour after 9:00 AM.	S 298		

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	NVS2681HOS	A. BUILDING _____ B. WING _____	05/08/2009

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S 298	Continued From page 17 Chapter 5.003 of the facility's medication administration policy under sub-heading #13 indicated "if a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time..., the space provided on the front of the [MAR] for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for [as needed] documentation." Patient #14's MAR lacked the above documentation. The facility failed to follow its policy regarding timely medication administration. During administration of the medication at 11:48 AM, Employee #25 proceeded to flush an IV port with 10 milliliters of saline prior to administering the IV bag with Pantoprazole. On 5/8/09 at 11:15 AM, Employee #1 indicated the facility used 10 milliliter syringes with pre-filled saline for routine flushes. Nurses were supposed to use 5 milliliters before and 5 milliliters after an intravenous medication administration. The facility's intravenous catheter care policy, last reviewed June 2007, indicated the following regarding routine flushes for peripherally inserted central catheters: Three milliliters normal saline followed by 3 milliliters of Heparin 100 units per milliliter. Patient #14's MAR indicated nurses administered 10 milliliters of saline with routine flushes and 5 milliliters of Heparin with routine flushes.	S 298		

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	NVS2681HOS	A. BUILDING _____ B. WING _____	05/08/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 298	Continued From page 18 The facility failed to follow its policy for routine flushing of peripherally inserted central catheters. Severity: 2 Scope: 2	S 298		
S 335 SS=D	NAC 449.363 Personel Policies 1. A hospital shall have written policies concerning the qualifications, responsibilities and conditions of employment for each type of hospital personnel, including the licensure and certification of each employee when required by law. This Regulation is not met as evidenced by: Based on interview, document review and personnel record review the facility failed to ensure written policies were in place to verify licensure and certification of each employee when required by law. Findings include: On 05/07/09 at 10:00 AM, a review of the facility's Policies and Procedures Manuals revealed there was no documented evidence of a written policy and procedure for verification of employee licensure and certification at the facility. On 05/07/09 at 2:50 PM, Employee #1 confirmed the facility had no documented evidence of a written policy or procedure in place to verify licensure and certification of employees at the facility. The facility had no written policies or procedures in place to address employee license renewal, suspension, restriction or revocation. Employee #1 indicated all employees licenses were checked on-line by her on a quarterly basis to verify they were current and that information was sent to the Board of Nursing. Employee #1	S 335		

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S 335	Continued From page 19 indicated it was her responsibility to make sure current copies of employees licenses and CPR (cardiopulmonary resuscitation) certificates were placed in all employees files at the facility. 1. Employee # 4 was hired on 11/05/07 as a Licensed Practical Nurse (LPN). A copy of the employees LPN license located in the personnel file indicated the license expired on 10/27/08. There was no documented evidence of a current copy of the employees nursing license located in the employees personnel record. 2. Employee # 5 was hired on 11/27/06 as a Registered Nurse (RN). A copy of the employees RN license located in the personnel file indicated the RN license expired on 08/06/07. There was no documented evidence of a current copy of the employees nursing license located in the employees personnel record. A copy of the employees American Heart Association CPR card indicated an expiration date of 06/07. There was no documented evidence of a current CPR card in the employees personnel record. The facility's Job Description and Competency Evaluation for Registered Nurses and License Practical Nurses last revised on 10/08, indicated both Registered Nurses and Licensed Practical Nurses were required to have a current Nevada nursing license and current CPR. Severity : 2 Scope: 1	S 335		
S 339 SS=D	NAC 449.363 Personel Policies 4. The hospital shall have evidence of a current license or certification on file at the hospital for each person employed by the hospital, or under contract with the hospital, who is required to be	S 339		

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	NVS2681HOS	A. BUILDING _____ B. WING _____	05/08/2009

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PROGRESSIVE HOSPITAL	4015 SOUTH MCLEOD LAS VEGAS, NV 89121

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S 339	Continued From page 20 licensed or certified by law to perform his job. This Regulation is not met as evidenced by: Based on interview, document review and personnel record review the facility failed to ensure two out of twenty four employees who were required to be licensed or certified by law had evidence of a current Nevada nursing license in their personnel record. (Employee #4, #5) Findings include: On 05/07/09 at 10:00 AM, a review of the facility's Policies and Procedures Manuals revealed there was no documented evidence of a written policy and procedure for verification of employee licensure and certification at the facility. On 05/07/09 at 2:50 PM, Employee #1 confirmed the facility had no documented evidence of a written policy or procedure in place to verify licensure and certification of employees at the facility. The facility had no written policies or procedures in place to address employee license renewal, suspension, restriction or revocation. Employee #1 indicated all employees licenses were checked on-line by her on a quarterly basis to verify they were current and that information was sent to the Board of Nursing. Employee #1 indicated it was her responsibility to make sure current copies of employees licenses and CPR (cardiopulmonary resuscitation) certificates were placed in all employees files at the facility. 1. Employee # 4 was hired on 11/05/07 as a Licensed Practical Nurse (LPN). A copy of the employees LPN license located in the personnel file indicated the license expired on 10/27/08. There was no documented evidence of a current copy of the employees nursing license located in the employees personnel record.	S 339		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2681HOS	A. BUILDING _____ B. WING _____	05/08/2009

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S 339	Continued From page 21 2. Employee # 5 was hired on 11/27/06 as a Registered Nurse (RN). A copy of the employees RN license located in the personnel file indicated the RN license expired on 08/06/07. There was no documented evidence of a current copy of the employees nursing license located in the employees personnel record. The facility's Job Description and Competency Evaluation for Registered Nurses and License Practical Nurses last revised on 10/08, indicated both Registered Nurses and Licensed Practical Nurses were required to have a current Nevada nursing license. Severity: 2 Scope: 1	S 339		
S 340 SS=F	NAC 449.363 Personel Policies 5. The hospital shall ensure that the health records of its employees contain documented evidence of surveillance and testing of those employees for tuberculosis in accordance with chapter 441A of NAC. This Regulation is not met as evidenced by: LCB File No. R084-06, Effective July 14, 2006 Sec. 10. NAC 441A.375 is hereby amended to read as follows: 441A.375 1. A case having tuberculosis or suspected case considered to have tuberculosis in a medical facility or a facility for the dependent must be managed in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 2. A medical facility, a facility for the dependent or a home for individual residential	S 340		

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	NVS2681HOS	A. BUILDING _____ B. WING _____	05/08/2009

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S 340	Continued From page 22 care shall maintain surveillance of employees of the facility or home for tuberculosis and tuberculosis infection. The surveillance of employees must be conducted in accordance with the recommendations of the Centers for Disease Control and Prevention for preventing the transmission of tuberculosis in facilities providing health care set forth in the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 3. Before initial employment, a person employed in a medical facility, a facility for the dependent or a home for individual residential care shall have a: (a) Physical examination or certification from a licensed physician that the person is in a state of good health, is free from active tuberculosis and any other communicable disease in a contagious stage; and (b) Tuberculosis screening test within the preceding 12 months, including persons with a history of bacillus Calmette-Guerin (BCG) vaccination. If the employee has only completed the first step of a 2-step Mantoux tuberculin skin test within the preceding 12 months, then the second step of the 2-step Mantoux tuberculin skin test or other single-step tuberculosis screening test must be administered. A single annual tuberculosis screening test must be administered thereafter, unless the medical director of the facility or his designee or another licensed physician determines that the risk of exposure is appropriate for a lesser frequency of testing and documents that determination. The risk of exposure and corresponding frequency of examination must be determined by following the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph	S 340		

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	NVS2681HOS	A. BUILDING _____ B. WING _____	05/08/2009

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PROGRESSIVE HOSPITAL	4015 SOUTH MCLEOD LAS VEGAS, NV 89121

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S 340	Continued From page 23 (h) of subsection 1 of NAC 441A.200. 4. An employee with a documented history of a positive tuberculosis screening test is exempt from screening with skin tests or chest radiographs unless he develops symptoms suggestive of tuberculosis. 5. A person who demonstrates a positive tuberculosis screening test administered pursuant to subsection 3 shall submit to a chest radiograph and medical evaluation for active tuberculosis. 6. Counseling and preventive treatment must be offered to a person with a positive tuberculosis screening test in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (g) of subsection 1 of NAC 441A.200. 7. A medical facility shall maintain surveillance of employees for the development of pulmonary symptoms. A person with a history of tuberculosis or a positive tuberculosis screening test shall report promptly to the infection control specialist, if any, or to the director or other person in charge of the medical facility if the medical facility has not designated an infection control specialist, when any pulmonary symptoms develop. If symptoms of tuberculosis are present, the employee shall be evaluated for tuberculosis. Based on interview, record review and document review the facility failed to ensure that 23 out of 24 health records of its employees had documented evidence of a physical exam and surveillance testing of employees for tuberculosis in accordance with chapter 441 A of NAC. (Employees #1, #2, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23,#24) Findings include:	S 340		

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	NVS2681HOS	A. BUILDING _____ B. WING _____	05/08/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROGRESSIVE HOSPITAL	4015 SOUTH MCLEOD LAS VEGAS, NV 89121

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S 340	Continued From page 24 On 05/06/09 at 12:30 PM, Employee #1 indicated she was not aware of the requirements of NAC 441A.375 and did not know that all employees were required to have a physical exam by a physician prior to employment that indicated the employee was in a good state of health and free from tuberculosis or any communicable disease. Employee #1 indicated the facility had no policy that required employees to complete a physical exam by a physician prior to participating in patient care. Employee #1 indicated she was not aware employees were required to have documentation of a 2-step tuberculin skin test prior to employment. 1. Employee #1 was hired on 10/02/02. There was no documented evidence of a two step Mantoux tuberculin skin test in the employees personnel file or physical examination or certification from a licensed physician that indicated the employee was in a good state of health and free from tuberculosis or any other communicable disease. 2. Employee #2 was hired on 06/08/05. There was no documented evidence of a two step Mantoux tuberculin skin test in the employees personnel file or physical examination or certification from a licensed physician that indicated the employee was in a good state of health and free from tuberculosis or any other communicable disease. 3. Employee #4 was hired on 11/05/07. A Tuberculin Testing for Employees form dated 03/29/08 indicated the employee had a positive 12 mm (millimeter) Mantoux tuberculin skin test. There was no documented evidence of a follow-up chest x-ray or tuberculin signs and	S 340		

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	NVS2681HOS	A. BUILDING _____ B. WING _____	05/08/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROGRESSIVE HOSPITAL	4015 SOUTH MCLEOD LAS VEGAS, NV 89121

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S 340	Continued From page 25 symptoms checklist in the employees personnel file. 4. Employee #5 was hired on 11/27/06. A facility Annual Chest X-Ray Follow-Up form dated 03/25/08 indicated the employee had a history of a reaction to a Mantoux tuberculin skin test and elected to have a chest x-ray. There was no documented evidence of an initial Mantoux tuberculin skin test result or chest x-ray result in the employees personnel file. There was no documented evidence of a physical examination or certification from a licensed physician that indicated the employee was in a good state of health and free from tuberculosis or any other communicable disease. 5. Employee #6 was hired on 05/08/03. There was no documented evidence of a physical examination or certification from a licensed physician in the employees personnel file that indicated the employee was in a good state of health and free from tuberculosis or any other communicable disease. 6. Employee #7 was hired on 04/07/09. There was no documented evidence of a physical examination or certification from a licensed physician in the employees personnel file that indicated the employee was in a good state of health and free from tuberculosis or any other communicable disease. 7. Employee #8 was hired on 05/11/05. There was no documented evidence of a two step Mantoux tuberculin skin test in the employees personnel file or physical examination or certification from a licensed physician that indicated the employee was in a good state of health and free from tuberculosis or any other	S 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2681HOS	A. BUILDING _____ B. WING _____	05/08/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 340	Continued From page 26 communicable disease. 8. Employee #9 was hired on 01/18/08. There was no documented evidence of a two step Mantoux tuberculin skin test in the employees personnel file or physical examination or certification from a licensed physician that indicated the employee was in a good state of health and free from tuberculosis or any other communicable disease. 9. Employee #10 was hired on 04/24/06. There was no documented evidence of a physical examination or certification from a licensed physician in the employees personnel file that indicated the employee was in a good state of health and free from tuberculosis or any other communicable disease. 10. Employee #11 was hired on 11/14/07. There was no documented evidence of a two step Mantoux tuberculin skin test in the employees personnel file or physical examination or certification from a licensed physician that indicated the employee was in a good state of health and free from tuberculosis or any other communicable disease. 11. Employee #12 was hired on 04/19/09. There was no documented evidence of a two step Mantoux tuberculin skin test in the employees personnel file or physical examination or certification from a licensed physician that indicated the employee was in a good state of health and free from tuberculosis or any other communicable disease. 12. Employee #13 was hired on 02/25/08. There was no documented evidence of a two step Mantoux tuberculin skin test in the employees	S 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2681HOS	A. BUILDING _____ B. WING _____	05/08/2009

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PROGRESSIVE HOSPITAL	4015 SOUTH MCLEOD LAS VEGAS, NV 89121

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S 340	Continued From page 27 personnel file or physical examination or certification from a licensed physician that indicated the employee was in a good state of health and free from tuberculosis or any other communicable disease. 13. Employee #14 was hired on 10/14/08. There was no documented evidence of a physical examination or certification from a licensed physician in the employees personnel file that indicated the employee was in a good state of health and free from tuberculosis or any other communicable disease. 14. Employee #15 was hired on 03/01/07. There was no documented evidence of a physical examination or certification from a licensed physician in the employees personnel file that indicated the employee was in a good state of health and free from tuberculosis or any other communicable disease. 15. Employee #16 was hired on 09/18/08. There was no documented evidence of a two step Mantoux tuberculin skin test in the employees personnel file or physical examination or certification from a licensed physician that indicated the employee was in a good state of health and free from tuberculosis or any other communicable disease. 16. Employee #17 was hired as a Registered Dietician. There was no documented evidence of a two step Mantoux tuberculin skin test in the employees personnel file or physical examination or certification from a licensed physician that indicated the employee was in a good state of health and free from tuberculosis or any other communicable disease.	S 340		

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	NVS2681HOS	A. BUILDING _____ B. WING _____	05/08/2009

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S 340	Continued From page 28 17. Employee #18 was hired as a Registered Dietician. There was no documented evidence of a two step Mantoux tuberculin skin test in the employees personnel file or physical examination or certification from a licensed physician that indicated the employee was in a good state of health and free from tuberculosis or any other communicable disease. 18. Employee #19 was hired on 06/27/06. There was no documented evidence of a two step Mantoux tuberculin skin test in the employees personnel file or physical examination or certification from a licensed physician that indicated the employee was in a good state of health and free from tuberculosis or any other communicable disease. 19. Employee #20 was hired on 01/03. There was no documented evidence of a two step Mantoux tuberculin skin test in the employees personnel file or physical examination or certification from a licensed physician that indicated the employee was in a good state of health and free from tuberculosis or any other communicable disease. 20. Employee #21 was hired on 03/09. There was no documented evidence of a physical examination or certification from a licensed physician in the employees personnel file that indicated the employee was in a good state of health and free from tuberculosis or any other communicable disease. 21. Employee #22 was hired on 11/03. There was no documented evidence of a two step Mantoux tuberculin skin test in the employees personnel file or physical examination or certification from a licensed physician that indicated the employee was in a good state of health and free from	S 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2681HOS	A. BUILDING _____ B. WING _____	05/08/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROGRESSIVE HOSPITAL	4015 SOUTH MCLEOD LAS VEGAS, NV 89121

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S 340	Continued From page 29 tuberculosis or any other communicable disease. 22. Employee #23 was hired on 08/08. There was no documented evidence of a two step Mantoux tuberculin skin test in the employees personnel file or physical examination or certification from a licensed physician that indicated the employee was in a good state of health and free from tuberculosis or any other communicable disease. 23. Employee #24 was hired on 01/06. There was no documented evidence of a two step Mantoux tuberculin skin test in the employees personnel file or physical examination or certification from a licensed physician that indicated the employee was in a good state of health and free from tuberculosis or any other communicable disease. The facility's Infection Control Policy last revised 10/08 documented the following: "All healthcare facility personnel will receive a Mantoux intradermal tuberculin skin test on employment and before patient care contact is initiated unless a previously positive reaction, completion of adequate prophylactic chemotherapy, or completion of an adequate therapeutic regime for active disease can be clearly documented. A two-step tuberculin screening test will be used in all new employees who have not had a documented recent tuberculin test within the last 12 months." Severity: 2 Scope: 3	S 340		